

Indiana State Department of Health
State Form 51000 (R/10-05)

1 Print firmly and neatly.
2 Only use pens with blue or black ink.
3 Fill in circles like this: ●
 Not like this: ✗
 Mark mistakes like this: ✗
4 Print capital letters only and numbers completely inside boxes.

A	2	C	3
---	---	---	---

5 Please complete all items on form.
6 **Date format:**
MM/DD/YY

Last Name _____

First Name _____ **MI** _____ **Phone Number** _____ - _____ - _____

Number & Street Address _____

City _____ **State** _____ **ZIP Code** _____ - _____

County _____ **Date of Birth** ____/____/____ **Age** _____

Race:
☐ Asian
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other/Multiracial
☐ Unknown

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Sex:
☐ Male
☐ Female
☐ Unknown

Is Age in day/mo/yr?
☐ Days
☐ Months
☐ Years

____/____/____
Date of Onset

☐ Yes ☐ No

If Yes, admission date: / /

Discharge date: / /

Hospital: | | | | | | | | | | | | | | | | | | | | | |

Patient chart number: | | | | | | | | | |

Physician: | | | | | | | | | | | | | | | | | |

Physician phone: | | | - | | | - | | | |

☐ Survived ☐ Died ☐ Unknown

If Died, date: / /

Indiana State Department of Health
State Form 51000 (R/10-05)

THIS FORM CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 1-2.3

INVASIVE MENINGOCOCCAL DISEASE CASE INVESTIGATION - Page 3 of 4

Indiana State Department of Health
State Form 51000 (R/10-05)

Section 3. Other Case Information and Contact Assessment

Employment Status:

☐ Full-time ☐ Part-time ☐ Unemployed

If employed, name of employer

Type of employment

Job duties

Does this patient attend school or day care?

☐ Yes ☐ No ☐ Unknown

If Yes, name of school/day care

Address

Contact name

_____-_____-_____
Contact phone

Does this patient attend a college or university?

☐ Yes ☐ No ☐ Unknown

If Yes, name of college/university

Address

Contact name

_____-_____-_____
Contact phone

Year in college/university?

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Other

College/University housing?

☐ Dormitory ☐ Apartment ☐ Single Family Home with Family ☐ Single Family Home with Student ☐ Other

If Other, specify

Has the patient traveled outside of the county in the past 14 days?

☐ Yes ☐ No ☐ Unknown

If Yes, specify travel location(s)

Travel dates: From ____/____/____ to ____/____/____

Mode of transportation?

☐ Automobile ☐ Train ☐ Bus ☐ Airplane

INVASIVE MENINGOCOCCAL DISEASE CASE INVESTIGATION - Page 4 of 4

Indiana State Department of Health
State Form 51000 (R/10-05)

Section 3. Other Case Information and Contact Assessment (continued)

For airplane travel, specify:

Was flight 8 hours or longer (including ground time)?

☐ Yes ☐ No

If Yes, airline name

Flight number

Has the patient ever received meningococcal vaccine?

☐ Yes ☐ No ☐ Unknown

If Yes, reason for vaccine?

☐ College Entrance ☐ Travel ☐ Functional or Anatomic Asplenia ☐ Other

If Other, specify

Section 4. Additional Close Contact Assessment

In the 7 days prior to illness onset, did any of the following transmission risks exist (check all that apply)?

Household exposures:

☐ Sleepovers ☐ Military Service ☐ Jail/Prison ☐ Shelter ☐ Other

If Other, specify

Sharing secretions:

☐ Kissing ☐ Shared Toothbrush ☐ Shared Food/Drink ☐ Shared Drugs
☐ Shared Band Instruments ☐ Shared Utensils ☐ Shared Cigarettes ☐ Other

If Other, specify

Section 5. Comments/Follow-up

Comments:

Investigator Name

Agency

_____-_____-_____/_____/_____
Phone Number Date